

STATEMENT OF EMERGENCY

907 KAR 1:170E

(1) This emergency administrative regulation which increases adult day health care service reimbursement rates by ten (10) percent beginning July 1, 2006, must be enacted to comply with House Bill 380 of the 2006 Session of the General Assembly and on an emergency basis to comply with House Bill 380 of the 2006 Session of the General Assembly.

(2) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(3) The ordinary administrative regulation is identical to the emergency administrative regulation.

Ernie Fletcher
Governor

Mark D. Birdwhistell, Secretary
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Long Term Care and Disability Services

4 (Emergency Amendment)

5 907 KAR 1:170E. Reimbursement for home and community based waiver services.

6 RELATES TO: 42 C.F.R. 441 Subparts B, G, 42 U.S.C. 1396 a, b, d, n

7 STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)[~~EO 2004-~~
8 ~~726~~]

9 NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004,~~
10 ~~reorganized the Cabinet for Health Services and placed the Department for Medicaid Ser-~~
11 ~~vices and the Medicaid Program under the Cabinet for Health and Family Services.] The~~
12 Cabinet for Health and Family Services, Department for Medicaid Services, is required
13 to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by admin-
14 istrative regulation, to comply with any requirement that may be imposed, or opportunity
15 presented, by federal law for the provision of medical assistance to Kentucky's indigent
16 citizenry. This administrative regulation establishes the method for determining amounts
17 payable by the Medicaid Program for services provided by home and community based
18 waiver service providers to an eligible recipient as an alternative to nursing facility care.

19 Section 1. Definitions. (1) "ADHC" means adult day health care.

20 (2) "ADHC center" means an adult day health care center:

(a) Licensed in accordance with 902 KAR 20:066, Section 4; and (b) Certified for Medicaid participation by the department.

(3) "Cost report" means the Home Health and Home Community Based Cost Report and the Home Health and Home and Community Based Cost Report Instructions.

(4) "DD" means developmentally disabled.

(5) "Department" means the Department for Medicaid Services or its designee.

(6) "Fixed upper limit" means the maximum amount the department shall reimburse for a unit of service.

(7) "HCB recipient" means an individual who:

(a) Meets the criteria for a recipient as defined in KRS 205.8451; and

(b) Meets the criteria for HCB waiver services as established in 907 KAR 1:160.

(8) "Home and community based waiver" or "HCB waiver" means home and community based waiver services.

(9) "Level I" means a reimbursement rate of up to thirty (30) dollars and eighty (80) cents [~~twenty-eight (28) dollars~~] paid to an ADHC center for a basic unit of service provided by the ADHC center to an individual designated as HCB waiver.

(10) "Level II" means a reimbursement rate of up to thirty-seven (37) dollars and forty (40) cents [~~thirty-four (34) dollars~~] paid to an ADHC center for a basic unit of service provided by the ADHC center to an individual designated as HCB waiver, if the ADHC center meets the criteria established in Sections 5 and 6 of this administrative regulation.

(11) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(12) "Quality improvement organization" or "QIO" is defined in 42 C.F.R. 475.101.

Section 2. Payment Amounts for HCB Waiver Covered Services Prior to July 1, 2001.

(1) An HCB waiver provider providing services to an HCB recipient shall comply with the provisions established in 907 KAR 1:031 and 907 KAR 1:160.

(2) An HCB waiver provider shall be reimbursed in accordance with the reimbursement methodology established in 907 KAR 1:031 for the following HCB waiver services:

(a) Assessment;

(b) Reassessment;

(c) Case management;

(d) Homemaker; or

(e) Personal care.

(3) For a rate determined in accordance with the reimbursement methodology established in 907 KAR 1:031, the department shall apply a fixed upper limit which shall apply regardless of the length of time a provider has participated in the Medicaid Program.

(4) The fixed upper limit for an HCB waiver service shall be set:

(a) Using each HCB waiver provider's average unit cost per service which shall be:

1. Grouped by service; and

2. Arrayed from lowest to highest;

(b) Using the median per unit cost for each service array based on the median number of Medicaid units; and

(c) At 130 percent of the median cost per unit.

(5) The department shall:

(a) Use an HCB waiver provider's most recent cost report data available as of May 31

1 to determine the provider's rate for the next state fiscal year, which begins July 1;

2 (b) Update upper limits each July 1; and

3 (c) Except as provided in subsection (3) of this section, not apply upper limits until a
4 provider has participated in the program for two (2) full agency fiscal years.

5 (6) If a provider fails to submit a cost report to the department before May 31, that
6 provider's rates for HCB waiver services shall remain the same as those of the previous
7 fiscal year, until receipt of an acceptable cost report.

8 (7) Payment for a covered respite service shall:

9 (a) Be limited to \$2,000 per six (6) month period within a calendar year beginning
10 January 1 through June 30 and July 1 through December 31;

11 (b) Not exceed \$4,000 per calendar year for a period beginning January 1 through
12 December 31;

13 (c) Be subject to a year-end cost settlement by the department:

14 1. To actual cost up to \$4,000; or

15 2. To charges, if lower; and

16 (d) Be made upon receipt of a claim to the department by an HCB waiver provider
17 pursuant to 907 KAR 1:673.

18 (8) Payment for a minor home adaptation to an HCB recipient's home shall:

19 (a) Be made on the basis of actual billed charges;

20 (b) Be for the actual cost of the minor home adaptation, including actual overhead
21 cost which shall not exceed twenty (20) percent of actual cost;

22 (c) Not exceed a maximum of \$500 per calendar year per HCB recipient beginning
23 January 1; and

(d) Be subject to a year-end cost settlement by the department:

1. To actual cost up to \$500; or

2. To charges, if lower.

(9) An attendant care service shall:

(a) Be reimbursed on a fee for service basis at the lower of reasonable cost or charge not to exceed the Medicaid upper limit of eleven (11) dollars and fifty (50) cents per unit of service;

(b) Be reported as nonreimbursable cost in an HCB waiver provider's cost report; and

(c) Not be subject to year-end cost settlement.

(10) Attendant care shall be limited to forty-five (45) hours per week and travel time for an attendant shall not be included in a unit of service.

Section 3. Audits of HCB Waiver Providers. HCB waiver cost reports shall be audited:

(1) As deemed necessary by the department; and

(2) To ensure that final payment to a provider is made in accordance with 907 KAR 1:031.

Section 4. Reimbursement for an ADHC Service. (1) Reimbursement shall:

(a) Be made:

1. Directly to an ADHC center; and

2. For a service only if the service was provided on site and during an ADHC center's posted hours of operation;

(b) If made to an ADHC center for a service not provided during the center's posted hours of operation, be recouped by the department; and

(c) Be limited to ten (10) units per week [~~beginning May 19, 2003-~~] at each HCB re-

1 recipient's initial review or recertification.

2 (2) Level I reimbursement shall be the lesser of the provider's usual and customary
3 charges or thirty (30) dollars and eighty (80) cents [~~twenty-eight (28) dollars~~] per unit of
4 service.

5 (3) Level II reimbursement shall be the lesser of the provider's usual and customary
6 charges or thirty-seven (37) dollars and forty (40) cents [~~thirty-four (34) dollars~~] per unit
7 of service.

8 (4) The department shall not reimburse an ADHC center for more than two (2) basic
9 units of service per day per HCB recipient.

10 (5) An ADHC basic daily service shall:

11 (a) Constitute care for one (1) HCB recipient;

12 (b) Be a minimum of:

13 1. Three (3) hours per day for one (1) unit; or

14 2. Two (2) hours for one (1) unit if the HCB recipient has occupied the ADHC center
15 for two (2) hours prior to leaving the center due to a documented illness or emergency;

16 (c) Be a minimum of six (6) hours for two (2) units; and

17 (d) Not exceed two (2) units per day.

18 (6) An ADHC center may request a Level II reimbursement rate for an HCB recipient
19 if the ADHC center meets the following criteria:

20 (a) The ADHC center has an average daily census limited to individuals designated
21 as:

22 1. HCB waiver;

23 2. Private pay; or

1 3. Covered by insurance; and

2 (b) The ADHC center has a minimum of eighty (80) percent of its individuals meeting
3 the requirements for DD as established in Section 5(2) of this administrative regulation.

4 (7) If an ADHC center does not meet the Level II requirements established in Section
5 5 of this administrative regulation, the ADHC center shall be reimbursed at a Level I
6 payment rate for the quarter for which the ADHC center requested Level II reimburse-
7 ment.

8 (8) To qualify for Level II reimbursement, an ADHC center that was not a Medicaid
9 provider before July 1, 2000 shall:

10 (a) Have an average daily census of at least twenty (20) individuals who meet the cri-
11 teria established in subsection (6)(a) of this section; and

12 (b) Have a minimum of eighty (80) percent of its individuals meet the definition of DD
13 as established in Section 5(2) of this administrative regulation.

14 (9) To qualify for reimbursement as an ancillary therapy, a service shall be:

15 (a) Medically necessary;

16 (b) Ordered by a physician; and

17 (c) Limited to:

18 1. Physical therapy provided by a physical therapist as defined in 907 KAR 1:160,
19 Section 1(18);

20 2. Occupational therapy provided by an occupational therapist as defined in 907 KAR
21 1:160, Section 1(17); or

22 3. Speech therapy provided by a speech pathologist as defined in 907 KAR 1:160,
23 Section 1(23).

1 (10) Ancillary therapy service reimbursement shall be:

2 (a) Per HCB recipient per encounter; and

3 (b) The usual and customary charges not to exceed the Medicaid upper limit of sev-
4 enty-five (75) dollars per encounter per HCB recipient.

5 (11) A respite service shall:

6 (a) Be provided on site in an ADHC center; and

7 (b) Be provided pursuant to 907 KAR 1:160.

8 (12) One (1) respite service unit shall equal one (1) hour to one (1) hour and fifty-nine
9 (59) minutes.

10 (13) The length of time an HCB recipient receives a respite service shall be docu-
11 mented.

12 (14) A covered respite service shall be reimbursed as established in Section 8 of this
13 administrative regulation.

14 Section 5. Criteria for DD ADHC Level II Reimbursement. To qualify for Level II reim-
15 bursement:

16 (1) An ADHC center shall meet the requirements established in Section 4 of this ad-
17 ministrative regulation; and

18 (2) Eighty (80) percent of its ADHC service individuals shall have:

19 (a) A substantial disability that shall have manifested itself before the individual
20 reaches twenty-two (22) years of age;

21 (b) A disability that shall be attributable to mental retardation or a related condition
22 which shall include:

23 1. Cerebral palsy;

1 2. Epilepsy;
2 3. Autism; or
3 4. A neurological condition that results in impairment of general intellectual function-
4 ing or adaptive behavior, such as mental retardation, which significantly limits the indi-
5 vidual in two (2) or more of the following skill areas:

- 6 a. Communication;
- 7 b. Self-care;
- 8 c. Home-living;
- 9 d. Social skills;
- 10 e. Community use;
- 11 f. Self direction;
- 12 g. Health and safety;
- 13 h. Functional academics;
- 14 i. Leisure; or
- 15 j. Work; and

16 (c) An adaptive behavior limitation similar to that of a person with mental retardation,
17 including:

- 18 1. A limitation that directly results from or is significantly influenced by substantial
19 cognitive deficits; and
- 20 2. A limitation that may not be attributable to only a physical or sensory impairment or
21 mental illness.

22 Section 6. The Assessment Process for Level II ADHC Reimbursement. (1) To apply
23 for Level II ADHC reimbursement, an ADHC center shall contact the QIO on the first of

1 the month prior to the end of the current calendar quarter. If the first of the month is on a
2 weekend or holiday, the ADHC center shall contact the QIO the next business day.

3 (2) The QIO shall be responsible for randomly determining the date each quarter for
4 conducting a Level II assessment of an ADHC center.

5 (3) In order for an ADHC center to receive Level II reimbursement:

6 (a) An ADHC center shall:

7 1. Document on a MAP-1021 form that it meets the Level II reimbursement criteria
8 established in Section 5 of this administrative regulation;

9 2. Submit the completed MAP-1021 form to the QIO via facsimile or mail no later
10 than ten (10) working days prior to the end of the current calendar quarter in order to be
11 approved for Level II reimbursement for the following calendar quarter; and

12 3. Attach to the MAP-1021 form a completed and signed copy of the "Adult Day
13 Health Care Attending Physician Statement" for each individual listed on the MAP-1021
14 form;

15 (b) The QIO shall review the MAP-1021 form submitted by the ADHC center and de-
16 termine if the ADHC center qualifies for Level II reimbursement; and

17 (c) The department shall review a sample of the ADHC center's Level II assessments
18 and validate the QIO's determination.

19 (4) If the department invalidates an ADHC center Level II reimbursement assess-
20 ment, the department shall:

21 (a) Reduce the ADHC center's current rate to the Level I rate; and

22 (b) Recoup any overpayment made to the ADHC center.

23 (5) If an ADHC center disagrees with an invalidation of a Level II reimbursement de-

1 termination, the ADHC center may appeal in accordance with 907 KAR 1:671, Sections
2 8 and 9.

3 Section 7. [~~Payment Rate for State Fiscal Year (SFY 2002). Effective July 1, 2001~~
4 ~~the payment rate that was in effect on June 30, 2001 for a home and community based~~
5 ~~waiver service shall remain in effect until June 30, 2002.~~

6 ~~Section 8.]~~ Fixed Upper Payment Rate Limits. (1) Except as provided in Section 4 of
7 this administrative regulation, [~~effective July 1, 2002~~] the payment rate for a home and
8 community based waiver service provided in accordance with 907 KAR 1:160 shall be
9 the lessor of billed charges or the fixed upper payment rate for each unit of service. The
10 following rates shall be the fixed upper payment rate limits:

Home and Community Based Waiver Service	Fixed Upper Payment Rate Limit	Unit of Service
Assessment	\$75.00	Entire assessment process
Reassessment	\$75.00	Entire reassessment Process
Case Management	\$15.00	15 minutes
Homemaking	\$13.00	30 minutes
Personal Care	\$15.00	30 minutes
Attendant Care	\$11.50	1 hour (not to exceed 45 hours per week)

Respite	\$2,000.00 per six(6) months (January 1 through June 30 and July 1 through December 31, not to exceed \$4,000.00 per calendar year)	1 hour
Minor Home Adaptation	\$500.00 per calendar year	

(2) The services listed in subsection (1) of this section shall not be subject to cost settlement by the department.

(3) ~~A [For HCB recipients eligible for homemaking service prior to May 19, 2003, homemaking service shall not be limited until July 1, 2003, when homemaking service shall be limited to no more than four (4) units per week per HCB recipient. For HCB recipients eligible for homemaking service on or after May 19, 2003,]~~ homemaking service shall be limited to no more than four (4) units per week per HCB recipient.

Section 9. Appeal Rights. An HCB waiver provider may appeal department decisions as to the application of the administrative regulation as it impacts the provider's reimbursement in accordance with 907 KAR 1:671, Sections 8 and 9.

Section 10. Incorporation by Reference. (1) The following material is incorporated by reference:

- (a) "Map-1021, ADHC Payment Determination Form", August 2000 Edition;
- (b) "Adult Day Health Care Attending Physician Statement", August 2000 Edition;
- (c) "The Home Health and Home and Community Based Cost Report", May 1991 Edition; and

1 (d) "The Home Health and Home and Community Based Cost Report Instructions",
2 October 1999 Edition.

3 (2) This material may be inspected, copied, or obtained, subject to applicable copy-
4 right law, at the Department for Medicaid Services, 275 East Main Street, Frankfort,
5 Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 1:170E

REVIEWED:

Date

J. Thomas Badgett, MD, PhD, Acting Commissioner
Department for Medicaid Services

Date

Mike Burnside, Undersecretary
Administrative and Fiscal Affairs

APPROVED:

Date

Mark D. Birdwhistell, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:170E

Cabinet for Health Services

Department for Medicaid Services

Agency Contact Person: Stuart Owen or Stephanie Brammer-Barnes (564-6204)

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes the reimbursement methodology for home and community based waiver services.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary in order to establish the reimbursement methodology for home and community based waiver services.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the reimbursement methodology for home and community based waiver services.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing the reimbursement methodology for home and community based waiver services.
- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: The amendment increases adult day health care reimbursement rates, as mandated by House Bill 380 of the 2006 Session of the General Assembly, by ten (10) percent.
 - (b) The necessity of the amendment to this administrative regulation: The amendment is necessary to comply with House Bill 380 of the 2006 Session of the General Assembly.
 - (c) How the amendment conforms to the content of the authorizing statutes: The amendment satisfies the mandate established in House Bill 380 of the 2006 Session of the General Assembly.
 - (d) How the amendment will assist in the effective administration of the statutes: The amendment satisfies the mandate established in House Bill 380 of the 2006 Session of the General Assembly.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: This administrative regulation will affect adult day health care providers. The Department for Medicaid Services (DMS) estimates there are approximately 125 adult day health care providers.

- (4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment: Adult day health care providers will receive a ten (10) percent reimbursement increase for adult day health care services.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: DMS estimates the amendment will cost \$2,295,100 (\$1,595,100 federal funds and \$700,000 state funds) for State Fiscal Year 2006-2007.
 - (b) On a continuing basis: DMS estimates the amendment will cost \$2,301,100 (\$1,601,100 federal funds and \$700,000 state funds) for State Fiscal Year 2007-2008.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under the Social Security Act, Title XIX and state matching funds from the general fund will be utilized to fund the amendment.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The amendment to this administrative regulation does not increase any fee. Federal funds authorized under the Social Security Act, Title XIX and state matching funds from the general fund will be utilized to fund the amendment.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment to this administrative regulation does not establish directly or indirectly increase any fee.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)

The reimbursement increases established in this amendment are for adult day health care services as mandated by House Bill 380 of the 2006 Session of the General Assembly.